



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED KHALIFA MD
3100 TIMMONS LANE SUITE 250
HOUSTON TEXAS 77027

Respondent Name

INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative

Box Number 15

MFDR Tracking Number

M4-11-1998-01

MFDR Date Received

January 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay total billed amount even after request for reconsideration was done."

Amount in Dispute: \$161.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 23, 2010	99202	\$102.80	\$0.00
March 23, 2010	95861	\$6.47	\$6.30
March 23, 2010	95900	\$15.32	\$14.36
March 23, 2010	95904	\$12.56	\$11.72
March 23, 2010	A4556	\$28.00	\$15.94
TOTAL		\$161.43	\$48.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced and payment was issued, however no ANSI codes or explanation was provided to the requestor for the reduction in payment.

Issues

1. Did the requestor bill in conflict with the NCCI edits?
2. Did the insurance carrier issue payment pursuant to 28 Texas Administrative Code §134.203 (d) for HCPCS code A4556?
3. Did the insurance carrier issue payment pursuant to 28 Texas Administrative Code §134.203 for CPT codes 95861, 95900 and 95904?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
The requestor seeks reimbursement for CPT code 99202, review of the submitted documentation supports that the requestor submitted a copy of the Electromyography report dates March 23, 2010, however no documentation was submitted to support the billing of CPT code 99202, therefore reimbursement cannot be recommended for CPT code 99202 rendered on March 23, 2010.
The requestor seeks reimbursement for CPT codes 95861, 95900, 95904 and HCPCS code A4556 rendered on March 23, 2010. NCCI edits were performed to determine if the disputed charges contained edit conflicts that would affect reimbursement. No NCCI edit conflicts were identified, therefore the disputed services will be reviewed pursuant to 28 Texas Administrative Code §134.203(c) and (d).
2. 28 Texas Administrative Code §134.203 "(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."
The HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair". The requestor seeks reimbursement in the amount of \$25.00. The DMEPOS fee schedule is \$12.75 multiplied by 125% derives a MAR of \$15.94, therefore this amount is recommended.
3. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."
The CPT code 95861 has a MAR amount of \$182.60, the insurance carrier issued payment in the amount of \$176.30, therefore the requestor is entitled to an additional reimbursement in the amount of \$6.30.
The CPT code 95900 x 4 units has a MAR amount of \$81.87 x 4 units = \$327.48, the insurance carrier issued payment in the amount of \$313.12, therefore the requestor is entitled to an additional reimbursement in the amount of \$14.36.
The CPT code 95904 x 4 units has a MAR amount of \$72.06 x 4 units = \$288.24, the insurance carrier issued payment in the amount of \$276.52, therefore the requestor is entitled to an additional reimbursement in the amount of \$11.72.
4. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of \$48.32.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$48.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$48.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	October 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.